

Executive Summary

August 9-10, 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) hosted *Recovery Now! Summit* (RNS), bringing together nearly 200 in-person and virtual participants to collaboratively develop a national recovery agenda. Representatives included persons with lived experience of mental health or substance use challenges and recovery, substance use preventionists, harm reductionists, treatment and recovery support providers, researchers, staff of federal and state partners, and other allies.

This summit was designed to reflect and build upon the significant developments in recovery-related support, research, and advocacy since the first SAMHSA-sponsored recovery summits, which were held in the early 2000s. The goals of the summit were to gather perspectives on the current strengths, opportunities, and aspirations of recovery movements and recovery work; gather perspectives on progress toward recovery-oriented systems over the past two decades, and on current strengths, opportunities, and challenges in operationalizing recovery-oriented systems; and identify key themes for new directions for SAMHSA's recovery-related efforts in the 21st century.

Across the two days, speakers in the five plenary sessions provided context, background information, and food for thought for participants to carry into the breakout sessions, in which they engaged in dialogue around four topics: (1) centering living experience in diverse settings, (2) promoting recovery-ready and recovery-rich communities; (3) preparing the workforce and workplace for integrating peers in diverse settings; and (4) addressing disparities and promoting equity and inclusion.

Common Themes Across Dialogue Sessions

There were eight Common Themes Across Dialogue Sessions that emerged from the RNS:

1. **Specificity matters in thinking and talking about recovery-related concepts.** Many of the conversations during the RNS involved establishing common vocabularies. There were two concepts that participants thought merited extended dialogue: the distinction between *treatment*, *recovery*, and *recovery support services*; and defining lived experience.
2. **Recovery happens in community.** Throughout the RNS, participants noted that recovery happens in community through interactions with persons with (similar) lived experience. Supportive interpersonal relationships—that is, peers helping peers—foster recovery. RNS participants emphasized the importance of recovery in community because of the continued pull of systems toward clinical/medical acute models of care; the differences between the treatment and behavioral health systems-defined outcomes and community-defined ones; and the fact that peer support has inherent value separate from clinical care.
3. **Structural racism and classism impede recovery and recovery community-building.** A growing body of research indicates that structural discrimination resulting from the racial discourse of the War on Drugs is a fundamental cause of mental health and substance use disorder disparities among Black, Indigenous, and other people of color (BIPOC) and low-income persons. Participants noted that structural racism and classism are built into our mental health and substance use care systems, and that structural violence has both created oppressive conditions and established the terms by which individuals are pathologized, criminalized, and alienated, leading to overtreatment for mental health conditions and undertreatment for substance use disorders. Participants noted that these structural impediments/features are, in essence, stigma enacted as policy. To address them requires intentional enactment of equity-focused policies and practices.
4. **Lived experience should be at the center of helping systems—but centering is more than just adding peers.** Centering lived experience is an equity-focused practice that addresses implicit and structural bias in care systems that are built around control. Although having peer workers on staff or engaging persons with lived experience on an advisory council may be steps toward recovery-oriented systems of care (ROSCs),

they are not sufficient for centering lived experience in policy and practice. To do so means dismantling the pathology paradigm and embracing the social and relational dimensions of recovery that exist before, during, after the medical treatment—and often in lieu of.

5. **Peer integration is only as effective as the organizational culture and infrastructure that supports the work.** The integration of peers into diverse settings is only as effective as the organizational culture and infrastructure that supports the work. For peer work to be authentic and effective, organizations must, at minimum, align organizational policies and practices with peer principles and practice, develop specific roles and job descriptions that draw upon peer core competencies, provide supervision that is appropriate to peer work, and offer equitable pay to peer staff.
6. **Lived experience-based jobs/roles have expanded, but stigma keeps them from being fully valued.** The range and type of settings in which peer work is happening has expanded greatly over the past 2 decades—and there is an increasing body of research that demonstrates the value of peer support. Yet, peer labor is still undervalued for a variety of reasons the RNS participants discussed, which include settings that are not designed nor trained to value, know, and utilize the principles and values that ground peer support; peer workers being hired for entry-level, ancillary tasks; workplaces placing greater value in higher levels of formal education or professional credentials, and the primacy of the medical/clinical model itself. These three factors translate into low wages and meager employee benefits for lived experience-based jobs.
7. **Structural racism, classism, and stigma impede the growth of community-based, peer-run, peer-led organizations.** All things being equal, peer-led/peer-run/peer-governed organizations would have the resources they need to fulfill their role as the gold standard of recovery support services. RNS participants noted that the current funding system is unequal, leading to chronic underfunding and underinvestment in these community-based programs. The factors that affect their funding are structural, connected to the same equity issues and stigma noted previously for individuals. Instead of “fitting a square peg into a round hole,” new visions for alternative funding models are needed.
8. **Systems transformation is an incomplete, never-ending process.** Participants noted that, much like recovery, system transformation is an ongoing process not a destination. Although progress has been made toward ROSCs, significant issues persist. For systems to become and remain recovery-oriented, it is a never-ending process of mapping recovery resources and assets; developing leadership and other roles for persons with lived experience; developing and updating policies that support a recovery-orientation; creating and refreshing networks of recovery-centered services; developing sustainable funding mechanisms; and evaluating outcomes and impacts.

Thinking Beyond What Currently Exists

If systems transformation is the aim, and if recovery happens in community through interactions with persons with lived experience, then a logical question is: How do we create environments that maximize the opportunities for both to occur? Recovery-ready environments and recovery-rich communities are two concepts that focus on communities as the sites of healing, which build upon the earlier conceptualizations of recovery-oriented systems of care. Both require the creation of policies that shift our perspective from services and supports in an acute care delivery model to a model that fosters quality of life and wellness across people’s recovery journeys. They encourage “thinking beyond” what currently exists, to better connect individual recovery (personal transformation) to recovery-oriented systems of care (institutional transformation) to recovery-rich communities (community transformation).

Participants defined and described both concepts. They noted that to create them will require a concentrated focus on diversity, equity, inclusion, and social justice; adequate funding must be available for recovery-centered programs (not just programs that focus on crisis, disease/symptoms, and pathology); and fully funded/resourced alternatives to institutionalization in health care and criminal justice settings.

Toward a Recovery Agenda: Fostering Recovery-Centered Systems and Healthy Recovery Ecosystems in Recovery-Rich Communities

The outcome of the RNS resulted in an updated national recovery agenda. Across the 2-day summit, participants offered their thoughts and observations on how the Office of Recovery can promote recovery-centeredness across SAMHSA and can work with and in communities to transform systems to support recovery in the 21st century. Ten focus areas were identified as critical to this work, along with suggested approaches: (1) acknowledging structural harms and working to dismantle them; (2) engaging diverse lived experience, intentional inclusion, and meaningful representation for MH and SUD recovery leaders in policy setting; (3) addressing disparities and promoting equity; (4) collecting recovery-related data and measuring recovery outcomes; (5) prioritizing community-based, peer-run recovery supports and alternatives to clinical services in grantmaking; (6) building the capacity of community-based, peer-run organizations; (7) supporting the lived experience (peer) workforce; (8) collaborating with other federal agencies to promulgate a recovery agenda; (9) providing guidance to states on systems transformation; and (10) providing guidance to the field.